

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31842**

FILED OCT 11 1948

Registration District No. **271**

Primary Registration District No. **4542**

Registrar's No. **19**

**1. PLACE OF DEATH:**  
(a) County Webster  
(b) City or town Rogersville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

**3. (a) PRINT FULL NAME** Thomas Roy Kelley  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 7 1908  
(Month) (Day) (Year)

**8. AGE:** Years 39 Months 8 Days 9 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Greene Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Invalid

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**  
12. Name George Kelley  
13. Birthplace Greene Co. Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Linda Kelley  
15. Birthplace Greene Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Linda Warner (Mother)  
(b) Address Rogersville Mo.  
17. (a) Burial (b) Date thereof Aug 18-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Pembina Cem.

18. (a) Signature of funeral director Kelley & Son, Inc.  
(b) Address Rogersville Mo.  
19. (a) 9-29-48 (b) Lester W. Good  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Webster  
(c) City or town Rogersville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month Aug day 16  
year 1948 hour 11 minute 55 p.m.  
21. I hereby certify that I attended the deceased from April 12 1948 to August 16 1948  
that I last saw him alive on August 13 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions None  
(Include pregnancy within 3 months of death)

**PHYSICIAN**  
Major findings:  
Of operations No further  
Of autopsy No autopsy  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 2  
23. Signature P. R. White (M. D. or other) MD  
Address Fordland, Mo. Date signed 9/24/48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED  
District Health Officer No. 6,  
District File Number 1048-1141  
Date Filed 10-9-48

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed K. K. Kelley  
Licensed Embalmer No. 3334  
P. O. Address Hardlow me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.